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USE OF THE TRANSACTIONAL ANALYSIS EGO STATE CONCEPT  
TO MEASURE CLIENT CHANGE IN PSYCHOTHERAPY

by

Judith Emerson

A dissertation submitted in partial fulfillment  
of the requirements for the degree

of

DOCTOR OF PHILOSOPHY

in

Psychology

UTAH STATE UNIVERSITY  
Logan, Utah

1990

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Judith Emerson

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## ABSTRACT

Use of the Transactional Analysis Ego State Concept  
to Measure Client Change in Psychotherapy

by

Judith Emerson, Doctor of Philosophy

Utah State University, 1990

Major Professors: Michael R. Bertoch, Ed.D.; Keith T. Checketts, Ph.D.  
Department: Psychology

Although transactional analysis (TA) theory has been used by psychotherapists since its introduction by Eric Berne in the 1960s, the ego state functioning constructs, a seminal part of the theory, have not been adequately validated. Previous research has focused on whether therapy using TA methodology works. This study tested the TA ego state constructs by measuring client change occurring during psychotherapy and comparing those changes with predictions from the TA theory.

Fifty-six subjects, who were clients at a university counseling center in the Rocky Mountain region of the United States, were tested before and after therapy using two standardized instruments, the Adjective Check List (ACL) and the Brief Symptom Inventory (BSI) and client and therapist global ratings of success of therapy.

Critical Parent, Nurturing Parent, Adult, and Adapted Child ego state scores from the ACL all changed in the predicted directions and reached statistical significance. Free Child ego state score changes did not reach statistical significance.

Ego state scores correlated with BSI Global Severity Index in predicted directions and all correlations except Critical Parent were statistically significant. Changes in ego state scores did not correlate with client and therapist ratings of success with one exception--Nurturing Parent was related to Client ratings of success. Changes in ego state scores did not correlate with subject pretest symptomatology, number of sessions, or the therapist's level of experience.

Limitations of the study and recommendations for further research are discussed.

(73 pages)

## CHAPTER I

### INTRODUCTION

Eric Berne proposed a theory of personality and psychotherapy over 25 years ago, which he called Transactional Analysis (TA) (Berne, 1961). Theories of psychotherapy are often based on the ideas and experiences of one expert therapist who organizes his or her perceptions about the therapeutic process into a cohesive system of personality and change. TA theory followed this pattern of development. Berne conceptualized TA based on his experiences as a psychiatrist treating patients and recorded his ideas in his writings (Berne, 1947, 1961, 1963, 1964, 1966, 1970, 1972, 1977). While TA theory has been used by many therapists since and is included in psychotherapy textbooks, there have not been adequate research studies to validate its basic constructs.

#### The Problem

Researchers attempting to validate TA theory have done so by testing success of psychotherapy when TA-oriented treatment was used. Studies have shown that psychotherapy using TA concepts is successful (Bloom, 1978; Brown, 1973; Collins, 1985; Fanger, 1978; Friedman, 1979; Intarakumnend, 1976; Johnson, 1975; Johnston, 1985; May & Tierney, 1976; McNeel, 1982; Mincis & McFarren, 1982; Payton, Morris, & Beale, 1979; Sharpe, 1975; Sisson, 1977; Thomas, 1978; Walters, 1983). Psychotherapy research has also shown that TA-oriented psychotherapy is no more successful than psychotherapy based on other theoretical orientations (DeVincentis, 1974; Fetsch, 1979; Francisco, 1975; Goodstein, 1971; Knox, 1973; Leamon, 1982; Olson, Ganley, Vernon, & Dorsey, 1981; Simonis, 1977; Smith, Glass, & Miller, 1980; Stasiw, 1977).

This equality of effectiveness between TA psychotherapy and psychotherapy using other orientations raises an important question. Did the clients in these studies change because the theory behind the therapy was sound or because other unmeasured variables common to all types of psychotherapy were creating change? The success of TA-oriented therapy may not rest on the validity of TA theory. If client changes occurring in TA-oriented psychotherapy can be explained by other factors, such as client motivation or quality of client-therapist relationship, then simply demonstrating the success of psychotherapy using TA concepts is insufficient evidence to validate the TA constructs.

The problem, then, is that TA theory has not been adequately validated. Another approach to validation that tests the TA theory constructs themselves is needed. TA concepts must be shown to be related to actual client change in psychotherapy.

Smith, Glass, and Miller (1980) found, in their meta-analysis of psychotherapy outcome studies, an equality of effectiveness amongst different therapeutic orientations. One explanation that can be given for this equality is that there exists an underlying mechanism of change within the client that is activated regardless of the theoretical orientation of the therapist (Beutler & Hamblin, 1986; Stiles, Shapiro, & Elliott, 1986). If TA constructs could be used to measure this hypothetical mechanism of change, then the TA theory would be more soundly supported.

### Definitions

The following definitions are presented to facilitate understanding of TA concepts.

2. **Parent Ego State:** Ego state in which the individual feels, thinks, acts, talks, and responds just as one of his/her parents did when the individual was a child (Berne, 1972).
3. **Adult Ego State:** Ego state in which the individual appraises his/her environment objectively and calculates its possibilities and probabilities on the basis of past experience (Berne, 1972).
4. **Child Ego State:** Ego state in which the individual feels, thinks, acts, talks and responds just the way he/she did when he/she was a child of a certain age (Berne, 1972).
5. **Critical Parent:** That part of the Parent ego state that is prohibitive of expressions of the child (Berne 1961).
6. **Nurturing Parent:** That part of the Parent ego state that is nurturing and promotes growth (Berne, 1961)
7. **Free Child:** That part of the Child ego state that represents autonomous forms of behavior. (Berne, 1961).
8. **Adapted Child:** That part of the Child ego state that represents behavior under the influence of the Critical Parent (Berne, 1961).

### Purpose of the Study

In his writings about psychotherapy, Berne described how ego state functioning changes when client functioning improves. Berne associated an increase in the Adult ego state functioning, an increase in the Free part of the Child ego state functioning, and an increase in the Nurturing part of the Parent ego state functioning with client improvement in therapy. He also associated a decrease in the Adapted part of the Child ego state functioning and a decrease in the Critical part of the Parent ego state functioning with client improvement (Berne, 1961). This theory of ego state functioning change may be one way of describing actual client change.

By measuring ego state functioning before and after psychotherapy, TA theory predictions can be tested. If these predictions hold, regardless of therapist orientation, then the TA theory can be

considered one viable way of measuring client change. This conclusion could be further supported if other ways of measuring client change coincide with the ego state changes. Then the basic constructs of TA theory (ego state functioning) could be considered useful tools for conceptualizing client functioning and change.

The purpose of this study was to determine whether the TA theory of ego state changes associated with improved client functioning is a viable way of measuring client change in psychotherapy. This was done by first testing whether measures of the Adult, Free Child, and Nurturing Parent ego state functioning increased and measures of the Adapted Child and Critical Parent ego state functioning decreased for clients who had been in psychotherapy, regardless of therapist's theoretical orientation. This tested the viability of the basic predictions of TA theory. Then ego state functioning changes were related to other measures of client change. This tested whether ego state changes converged with other measures and could therefore be testing an underlying mechanism of client change. Finally, to further understand how TA constructs relate to the therapy process, variables that have been considered predictive of therapy outcome were related to the changes in ego state functioning.



## CHAPTER II

## REVIEW OF LITERATURE

The review of literature will cover four areas. First, an overview of TA theory, including a description of ego state functioning and how Eric Berne described change occurring in psychotherapy, will be presented. Second, previous research studies that have included a measure of change in ego state functioning following treatment will be reviewed. Third, other measures of client change that might correlate with measures of changes in ego state functioning will be discussed. Fourth, reviews of literature on variables that might predict the outcome of therapy will be presented.

Transactional Analysis Theory

Transactional Analysis (TA) is a theory of personality and psychotherapy developed by Berne in the 1960s. Berne described human personality as being made up of three distinct and coherent systems of thoughts and feelings with corresponding behavior patterns (Berne, 1972). He called these systems ego states. He named them Parent, Adult, and Child because of their origins and functions (Berne, 1961).

Berne suggested that an individual's Parent system is made up of behaviors copied from parent figures when the individual was a child. He said an individual's Child system is made up of naturally occurring feelings and adaptive behaviors that the individual learned in response to demands from his/her parents. Berne also suggested an individual's Adult system is made up of behaviors that function to process information and solve problems (Berne, 1966). These ego state concepts are seminal to TA theory of personality structure and function.

Berne discussed two types of Parent ego state functioning. The nurturing, growth-enhancing behaviors in this system were grouped together and critical, controlling behaviors were grouped together (Berne, 1961). These concepts have been presented by writers in the TA literature as Nurturing Parent and Critical Parent, respectively. Berne divided the concept of Child ego state in two parts. He grouped the naturally occurring child behaviors together and the adaptive child behaviors together (Berne, 1961). These concepts have been presented by TA writers as Free Child and Adapted Child, respectively.

Berne proposed that in psychotherapy, the client learns greater reality-based awareness and problem-solving skills, which he described as an increase in the Adult ego state functioning. He then suggested that once the Adult ego state is strengthened and in the executive position in the personality, the client can examine adaptive behaviors he/she learned as a child and change them for more autonomous behaviors. Berne describes replacing adaptive behaviors with more spontaneous, naturally occurring behaviors associated with greater self-confidence and increased self-esteem, as a decrease in Adaptive Child ego state functioning and an increase in Free Child ego state functioning.

According to Berne, this process of examination of Adaptive Child behaviors involves confronting the criticisms and prohibitions of the Critical Parent ego state system. These critical behaviors can then be replaced with self-nurturing, growth promoting behaviors. This process is described as a decrease in Critical Parent ego state functioning and an increase in Nurturing Parent ego state functioning (Berne, 1961).

Thus, in psychotherapy based on TA concepts, changes in ego state functioning are expected. The Adult ego state is increased, the Adapted

Child and Critical Parent ego states are decreased, and the Free Child and Nurturing Parent ego states are increased.

### TA Psychotherapy Outcome Studies

Six articles have been published that provide data on ego state functioning changes following treatment (Craig & Olson, 1988; Fetsch, 1979; Marsh & Drennan, 1976; McClenaghan, 1976; Sharpe, 1975; Walters, 1983). While these studies included ego state functioning as one of the dependent measures, only one (Craig & Olson) set out to test the theory of changes in ego state functioning as a result of therapy. The other five studies were examining the effectiveness of TA-oriented treatment. Each of the six studies had methodological weaknesses. A summary of these six studies is presented in Table 1.

Sharpe (1975) reported a study of 32 university counseling center clients who received 15 hours of group therapy based on TA theory. Ego state changes were measured by ratings of three judges who were trained in TA theory by the researcher. Inter-rater reliability coefficients were reported as ranging from .75 to .99. No construct validity data were reported. Adult and Free Child scores increased and Adapted Child scores decreased following treatment. There were no significant changes in Critical Parent and Nurturing Parent scores. While the findings partially support the TA theory of client change, the method of measurement was not standardized and had no demonstrated construct validity.

Table 1

Research Studies Reporting Ego State Functioning Change As ADependent Measure

Author Year	Subjects	Dependent Measure	Findings	Validity Threats
Sharpe 1975	32 university counseling center clients	Self-report egogram	Adult, Free Child scores increased. Critical Parent, Adapted Child scores decreased.	Non-standardized instrument. No validity data.
Marsh & Drennan 1976	1 mentally handicapped female	Client-report & Therapist- report egograms	Adult, Nurturing Parent, Free Child scores increased. Adapted Child scores decreased.	Single case study. Non-standardized instruments. No rel. or validity
McClenaghan 1976	74 college students & community volunteers	Transactional Behavior Questionnaire	No change	Treatment was education, not therapy. No rel. or validity data for instrument.
Fetsch 1979	16 clients with reactive depression	Transactional Behavior Questionnaire	Nurturing Parent, Free Child scores increased	Small sample
Walters 1983	22 women defined as passive.	Therapist- report egogram	Adult scores increased.	Three groups, finding based on sample of 7.
Craig & Olson 1988	68 addict inpatients	Adjective Check List	Adult scores increased. Adapted Child scores decreased.	Possible confounding of therapy and detoxification.

Marsh and Drennan (1976) reported a single case study of an intellectually handicapped female adult who was taught skills based on TA ego state concepts. The change in the client was measured subjectively by the therapist, who indicated an increase in Adult, Nurturing Parent, and Free Child ego state functioning and a decrease in Critical Parent and Adapted Child ego state functioning. While the findings of these authors were consistent with TA theory, the measurement of ego state change was subjective and without evidence of

reliability or validity. Also, generalizations from one case study are tentative at best.

McClenaghan (1976) studied 74 students and community volunteers who received 12 hours of TA-oriented education with homework exercises over 4 weeks. Ego state changes were measured as part of the development of the Transactional Behavior Questionnaire. Subjects were randomly assigned to treatment/no treatment conditions. No group differences were found on the ego state measure. The treatment was not psychotherapy but education. The instrument used had not been standardized and had no reported reliability or validity data.

Fetsch (1979) studied 16 subjects with reactive depression. He compared a TA-oriented "stroking" treatment with an exercise treatment that included running. He used the Transactional Behavior Questionnaire (Brennan & McClenaghan, 1978) which had, by then, been standardized. Fetsch found an increase in Free Child and Nurturing Parent scores in the TA treatment group. Ego state scores were reported for the TA-oriented treatment group only, which consisted of 8 subjects, and were not reported for the running treatment group. While these changes were in the direction predicted by TA theory, the sample was small and specific in diagnosis, which limits generalization of the findings.

Walters (1983) studied 22 female subjects who were diagnosed as "passive females." She assigned the subjects to one of three groups (TA therapy, Get Together group, and a control group). It is unclear whether this assignment was random or not. Seven subjects received TA-oriented therapy. Walters reported an increase in the Adult ego state functioning and a decrease in dependency in the group that received TA-oriented treatment. The decrease in dependency was greater for the TA

group than for the other two groups. The instrument she used was a therapist report of relative amounts of ego state functioning. These were subjective ratings and had no reliability or validity data reported. Even though Walters' results supported TA theory, the lack of standardized measurement and the small sample size reduce the internal and external validity of the findings.

Craig and Olson (1988) used the TA scales of the Adjective Check List (Williams & Williams, 1980) to determine ego state changes in 68 inpatient heroin addicts. The average length of treatment was 18 days and the treatment consisted of individual, group, recreation and milieu therapy along with educational seminars. The treatment was not TA oriented. This is the only study of the six that set out specifically to measure ego state functioning changes as a result of psychological treatment rather than to test the effectiveness of TA-oriented therapy. Craig and Olson used Gough's Adjective Check List, a standardized instrument with published reliability and validity data (Gough & Heilbrun, 1983). They found a statistically significant increase in the Adult ego state scores and a statistically significant decrease in Adapted Child ego state scores. Unfortunately, these researchers did not report any attempts to separate the effects of milieu and detoxification from the effects of therapy. Either one of those treatment variables could have influenced changes in ego state functioning. This study began to test the TA theory of ego state functioning change as a result of therapy but merits replication with subjects where the treatment variable is less confounded.

All but one of the studies reviewed provide some support for Berne's theory of client change in psychotherapy. None of them provide

compelling evidence, and each has threats to both internal and external validity. Three of the studies had very small samples sizes. Four used measures with questionable psychometric qualities. Five used TA-oriented treatment and the sixth study did not have a clear treatment effect due to possible confounding of intervening variables. Thus, the question of whether ego state functioning changes in psychotherapy merits further study.

### Collateral Measures of Client Change

Lambert, Shapiro, and Bergin (1986) suggest a variety of instruments that can be used to measure psychotherapy outcome. Some measures are completed by the client, including post-therapy satisfaction questionnaires, symptom checklists, self-monitoring forms, personality tests, and measures of self-esteem. Other measures are completed by trained observers, including standardized interviews and behavioral counts. A third group are measures completed by relevant others such as family members. These include measures of social adjustment and marital satisfaction. Fourth, the authors suggest using therapist's assessment of client change.

Global ratings of the success of therapy completed by clients and therapists at the end of treatment have been used for some time in therapy outcome research. These ratings are related to two of the measures suggested by Lambert, Shapiro, and Bergin, namely client satisfaction and therapist assessment of client change. Green, Gleser, Stone, and Seifert (1975) state:

The two most frequent methods of assessing outcome in psychotherapy research are direct improvement ratings and pretreatment-posttreatment difference scores. In either case, a global approach is often used. (p. 690)



Green et. al. conducted a study of the relationships between various therapy outcome measures and used global ratings of success from both the client and the therapist. They found that these ratings correlated with changes in symptomatology. They also found that the ratings had higher correlations with final status scores than with change scores (Green et al., 1975).

In a five-year study of the measurement of psychotherapy outcome, Mintz, Luborsky, and Christoph (1979) also used ratings of therapy success completed by both the client and the therapist. They found that the client and therapist ratings of improvement were related to residual gain scores for measures of adjustment. (Residual gain scores are computed by subtracting actual gain from predicted gain. Predicted gain is based on the individual's initial level. Thus these scores take into account individual differences at pretest.) They also found a correlation between the client and therapist ratings.

The other method of assessing outcome presented by Green et. al. (pretreatment-posttreatment differences) have been measured using self-report symptom checklists administered to the client at pretest and posttest. Symptom checklists are another of Lambert, Shapiro, and Bergin's suggested sources of outcome data. In an article describing the Hopkins Symptom Checklist, Derogatis, Lipman, Rickels, Uhlenhuth, and Covi (1974) list some of the advantages of self-report symptom checklists. They state that primarily, these checklists tap the source (the person experiencing the symptoms) and are not subject to the distortion inherent in second hand reports by clinicians or other observers. They also take little professional time to administer and are sensitive to treatment effects.



One criticism of self-rating scales is that they are inaccurate because subjects inflate the results to either look good or please the experimenter. A study by Lambert, Hatch, Kingston, and Edwards (1986) compared two self-report ratings of depression with an expert rating form of depression, which was completed by a trained observer. They found that contradictory to popular opinion, the self-reports yielded more conservative measures of change than did the expert rating. Their research data also indicated that self-report rating forms are sensitive to change which occurs following treatment (Lambert, Hatch, Kingston, & Edwards, 1986). In their recommendation of symptom checklists for assessing therapy outcome, Lambert, Shapiro, and Bergin (1986) state that when the population is diverse, multiple symptom checklist is a better choice, and the simple symptom checklist, such as a depression index, is best for homogeneous populations with that specific complaint.

#### Variables Predictive of Client Change

Several reviews of research on factors that affect outcome of psychotherapy were examined. The reviewers covered a multitude of variables. Three salient variables from the first review will be presented and then followed through the other reviews.

Luborsky, Chandler, Auerbach, Cohen, and Bachrach (1971) reviewed research on factors influencing outcome of psychotherapy. They stated:

When a patient and psychotherapist agree to meet, is what follows largely an unpredictable venture? Most psychotherapists believe it is predictable because patients, as a group, will improve; it is unpredictable because only a few of the factors influencing the fate of the individual patient in psychotherapy can be discerned, even after a thorough initial evaluation and even after the early sessions. All psychotherapists agree on this one fact: Some patients seem to improve; others do not. Responsibility for such differences could theoretically be traced to a variety of sources--the qualities of the patient and therapist, the mode of treatment, or some higher order interaction of these factors. (p. 145)

In their review of 166 studies of predictors of outcome of individual psychotherapy, they assessed client factors, therapist factors, and treatment factors. One conclusion about client factors was that clients who are "healthier" at the beginning of therapy improve more than those who are "sicker" at the beginning of therapy. A second conclusion was that there might be a positive relationship between therapist experience and client gains. A third conclusion was that a greater number of sessions appeared to be associated with more client change.

As part of their meta-analysis of 400 research studies, Smith, Glass, and Miller (1980) also examined client, therapist and treatment variables in relation to outcome. Their findings presented a different picture of what factors contribute to psychotherapy outcome. They stated that client diagnosis was related to outcome but they did not examine clients' level of functioning before therapy as a factor. They reported that the therapists' experience, training, and theoretical orientation did not appear to affect outcome. Additionally, they said duration of therapy had no "simple or consistent relationship" with outcome (Smith et al., 1980, p 115).

In Garfield and Bergin's text, Handbook of Psychotherapy and Behavior Change, Garfield (1986) stated that the research findings on client degree of disturbance and related variables at the beginning of therapy is equivocal due to the diversity of variables and methodologies used. In the same text, Beutler, Crago, and Arizmendi (1986) reviewed the research on therapist variables. They examined 23 studies and found only seven supported a positive relationship between therapist experience and therapy outcome. Orlinsky and Howard (1986) presented a review of treatment process variables in relation to therapy outcome in

the Garfield and Bergin text. They reported that the studies they examined supported the notion that the number of sessions is positively correlated to outcome, with the client gaining more in earlier sessions and making smaller gains in later sessions.

The three variables presented above, (1) client degree of disturbance at the beginning of therapy, (2) the therapist's experience, and (3) the number of sessions, may influence the outcome of therapy but their effects are not consistently supported. The effect of client level of functioning before therapy was supported by Luborsky et al., not examined by Smith et al., and reported as equivocal by Garfield. The effect of therapist experience was supported by Luborsky et al. but not by Smith et al., Glass and Miller, or Beutler et al. The effect of number of sessions was supported by Luborsky et al. and Orlinsky and Howard and reported as unclear by Smith et al., Luborsky et al., Garfield, Beutler et al., and Orlinsky and Howard were qualitative summaries. Smith et al. was a quantitative summary, utilizing a meta-analysis statistical method. These three variables have been of interest to psychotherapy outcome researchers for some time and there is some evidence that they may contribute to the outcome of psychotherapy.

### Summary

Eric Berne proposed a theory of personality and psychotherapy, describing the process and outcome of therapeutic change in clients. T.A. psychotherapy outcome research has not addressed the validity of this theory directly. Rather, it has assessed whether therapy using TA concepts works or not. The few studies that have incidently measured ego state functioning changes occurring during psychotherapy have methodological weaknesses and do not provide very strong evidence that

the changes occur as the theory predicts. The one study that did ask the question directly had confounding treatment variables. Thus the question of whether ego state functioning changes occur during psychotherapy is only partially supported and merits further research.

There are a number of measures of psychotherapy outcome that could be used as collateral data to relate ego state functioning changes to actual client change. Three that have precedence in the literature are: client and therapist global ratings of success of therapy and self-report symptom checklist completed before and after therapy.

Many researchers have attempted to define factors that contribute to client change. This body of research was summarized. Of the multitude of factors researched and discussed by the reviewers, three were selected which represent three domains (client factors, therapist factors, and therapy process factors). The reviewers' findings on these three factors, client pre-therapy functioning, therapist experience, and length of therapy, illustrate the equivocal nature of the results of research in this area. Whether these three factors predict therapy outcome is not altogether certain.

## CHAPTER III

## METHODOLOGY

The methodology will be described in four parts. The research questions will be listed first. Second, the selection procedure and demographic characteristics of the subjects will be presented. The instruments used to gather the data will be described third and the procedure for data collection will be presented fourth.

Research Questions

The four research questions for this study were as follows: 1) Do measures of the Critical Parent, Nurturing Parent, Adult, Free Child, and Adapted Child change for clients who have been in psychotherapy, regardless of therapist's theoretical orientation? 2) Are the posttest ego state scores related to posttest symptom severity scores? 3) Are the changes in ego state scores related to the client and therapist perceptions of success of therapy? 4) Are the changes in ego state scores related to client pretherapy symptomatology, number of sessions, or therapist experience?

Subjects

Clients coming to a university counseling center for therapy services were asked to consider participation in the study at the time they came to their initial intake interview. If the client signed an informed consent (see Appendix A), they were contacted by the researcher and asked to fill out pretest forms. They were contacted again at the end of therapy or four months, whichever came first, for posttesting.

The subjects were drawn from a population of clients seeking services at a university counseling center in the Northern Rocky

Mountain region of the United States between May, 1988, and April, 1989. One hundred and twenty-nine clients signed the informed consent to participate. Sixty-four of those clients were not included in the study for the following reasons. Sixteen started therapy without completing the pretest, 24 were referred outside the counseling center for services, and 24 did not come back after the intake and were terminated as "no shows."

Sixty-five subjects completed the pretest and received therapy at the counseling center. Nine of those 65 did not complete the posttest, leaving a total study sample of 56. The subjects with completed data had an average age of 26.59 (standard deviation of 6.38, range of 18-46); 48% were male; 55% were single; 36% married or living with a partner; 9% separated, divorced, or widowed; and 68% had no previous therapy experience. The average number of therapy sessions was 8.01, with a standard deviation of 6.26, and a range of 1-36 (one subject had 36 sessions, but all other subjects had between 1 and 19 sessions).

The subjects had a variety of diagnoses on Axis I and Axis II, which were assigned by the therapist according to DSM-III-R criteria. Sixty-three percent had a V-code diagnosis on Axis I and no diagnosis on Axis II. (V-code diagnoses are more transient problems, such as marital, academic or other interpersonal problems. Other Axis I diagnoses are more serious, such as affective disorders, schizophrenia or anxiety disorders. Axis II disorders are developmental in nature, such as personality disorders or intellectual limitations.) Sixteen percent had a more serious Axis I diagnosis (not a V-code) with no diagnosis on Axis II. Ten and a half percent had a diagnosis on both Axis I and II and 10.5% had no diagnoses reported by the therapist.

The subject sample was not randomly selected. Also clients seeking services at a university counseling center were not considered to be representative of the population of people seeking psychotherapy services in general. While the subjects were volunteers from a population of volunteers, they were also individuals who were genuinely seeking psychotherapy services for real complaints and therefore were considered appropriate subjects for this study.

### Instruments

Five instruments were used to collect the data. Two were published, standardized measures and three were designed by the researcher. The Adjective Check List (ACL) (Gough & Heilbrun, 1983) was used to measure ego state functioning before and after psychotherapy. The Brief Symptom Inventory (BSI) (Derogatis & Spencer, 1982) was used to measure client symptom severity before and after psychotherapy. A client Pretest Rating Form, a client Posttest Rating Form (see Appendix B), and a Therapist Posttherapy Rating form (see Appendix C) were designed by the researcher to measure client and therapist perceptions of the success of therapy.

Adjective Check List. The ACL is a 300-item, paper and pencil, self report measure. The respondent indicates which adjectives of the 300 listed he/she believes are descriptive of him/her. Williams and Williams (1980) developed five TA ego state scales, Critical Parent (CP), Nurturing Parent (NP), Adult (A), Free Child (FC) and Adapted Child (AC), for the ACL.

To develop the TA scales, Williams and Williams (1980) had 15 International Transactional Analysis Association certified members judge the adjectives on the ACL based on the adjectives' ability to describe



each of five ego state constructs. The adjectives selected for each ego state had the following inter-rater reliabilities: CP .93, NP .93, A .95, FC .94, and AC .89. Each TA scale has 44 items that are scored either +1 or -1 to give a raw score. The scales are non-ipsative, which means they are not computed in such a way that one scale automatically goes up as another goes down.

As reported in the ACL Manual, internal consistency reliability coefficients for each ego state score were computed using a sample of 1179 (591 male and 588 female). The coefficients were as follows for males: CP .76, NP .81, A .79, FC .72 and AC .79. The coefficients were as follows for females: CP .77, NP .77, A .77, FC .76, AC .77. Also reported in the manual were six month test-retest reliability coefficients for each ego state score, using a sample of 244 (199 male and 45 female). The coefficients were as follows for males: CP .74, NP .71, A .71, FC .70, AC .70. The coefficients for females were: CP .75, NP .73, A .71, FC .82, AC .64.

Three studies examining the construct validities of Critical Parent, Adult, and Free Child scores for the ACL were reported by Williams, Watson, Walters, and Williams (1983). Free Child scores correlated positively with measures of adventure and experience seeking and negatively with a measure of boredom. Adult scores correlated negatively with a measure of anxiety. Critical Parent scores correlated positively with a measure of perceived external locus of control and negatively with a measure of empathy. These findings support the descriptions of the functioning of these three ego states.

Gough and Heilbrun (1983) reported a factor analysis of the ACL using 591 male and 588 female subjects. Adult and Adapted Child scales



loaded positively and negatively, respectively, on the first factor, which they titled "potency." Free Child loaded positively on the second factor, which they titled "assertiveness." Nurturing Parent loaded positively on the third factor, which they called "sociability." Critical Parent was split between a negative loading on "sociability" and a positive loading on the fifth factor, which they called "dissatisfaction." These findings are consistent with the characteristics assigned to each construct.

A recently published research study used the Williams & Williams TA scales of the ACL to measure changes in ego state functioning in clients who had received inpatient treatment for drug abuse. Craig and Olson (1988, p. 68) concluded that, "the ACL can be used to objectively measure changes in ego states."

The norming sample used to convert the ACL ego state raw scores to standard T scores (mean 50, standard deviation 10) consisted of 5,238 males and 4,144 females. Forty-three percent of the sample were described by Gough and Heilbrun (1983) as "adults," 11% were high school students, 21% were undergraduate college students, 10% were graduate college students, 9% were medical students, 1% were law students, 4% were delinquents, and 1% were psychiatric patients. The authors stated that the normative sample is "ad hoc and arbitrary in composition... [and]...may not adequately represent general population trends" (Gough & Heilbrun, 1983, p. 29). For the current study, the subjects' scores for Critical Parent, Nurturing Parent, Adult, Free Child, and Adapted Child were converted to standard scores based on this norm group.

Brief Symptom Inventory. The BSI is a 53-item, paper and pencil, self-report instrument. The items are statements of psychiatric

symptoms, which are rated on a five-point scale from "not at all" to "extremely." The BSI has nine clinical symptom area scores and three global indices of distress.

Reliability data reported for the symptom dimensions consists of both internal consistency and stability. Cronbach's coefficient alphas for the nine dimensions were as follows: somatization .80; obsessive-compulsive .83; interpersonal sensitivity .74; depression .85; anxiety .81; hostility .78; phobic anxiety .77; paranoid ideation .77; psychoticism .71. Two week test-retest reliability coefficients for the nine dimensions were as follows: somatization .68; obsessive-compulsive .85; interpersonal sensitivity .85; depression .84; anxiety .79; hostility .81; phobic anxiety .91; paranoid ideation .79; psychoticism .78. Only test-retest reliability was reported for the Global Severity Index. The correlation coefficient was .90 (Derogatis & Spencer, 1982).

The authors reported that each of the BSI clinical scales correlated highly with the corresponding scale on the longer form, the SCL-90-R, with coefficients between .92 and .99. Correlations between the BSI symptom dimensions and MMPI clinical scales, Wiggins content scales, and Tryon subscales are reported. While the correlation coefficients are not large, ranging from .30 to .72 with a mean of .43, content areas correlated in a way that supports the construct validity of the symptom dimensions of the BSI. A factor analysis of the BSI yielded nine interpretable factors corresponding for the most part with the nine clinical scales (Derogatis & Spencer, 1982). Concurrent and predictive validity of the Global Severity Index is not reported in the BSI manual.

Four norm groups are described: 974 non-patient normals, 1,002 psychiatric outpatients, 423 psychiatric inpatients, and 2,408 adolescent non-patients. The outpatient norms were used to convert raw scores to standard T scores (mean of 50, standard deviation of 10). The psychiatric outpatient sample consisted of 425 males, 577 females, 66% caucasian, with greater representation of lower socioeconomic class than occurs in the general U.S. population.

Client and therapist global ratings of success. In an effort to collect data about client and therapist perceptions of the success of therapy, three instruments were designed by the researcher. The first two, a client Pretest Rating Form and a client Posttest Rating Form, were created to measure the client's perception of change in functioning and the client's rating of the success of therapy (See Appendix B). For use in this study only one item was analyzed from the client rating forms. That was question 11 on the posttest scale. On this item clients were asked to rate the success of therapy from one to ten. The Therapist Posttherapy Rating form was created to measure the therapist's perception of client change and the success of the therapy (See Appendix C). Only item 12, which measures the therapist global rating of the success of therapy, was analyzed for this study.

As noted above, the client pretest and posttest forms included both a measure of current level of functioning (the first 10 items) and a rating of the success of therapy. These two factors are conceptually different. One addresses how the client thinks he/she is getting along and the other addresses satisfaction with the therapy experience. The therapist form included three factors. One was a measure of client functioning (the first 10 items), another was whether termination was

premature or not and the third was a rating of the success of therapy. Again these are conceptually different factors.

Global ratings of the success of therapy have been used in research and their validity is reported in the literature. The remaining parts of these three instruments have unknown reliability and validity and have not been addressed in the research literature. Therefore, only the global ratings of success (item 11 on the client Posttest Rating Form and item 12 on the Therapist Posttherapy Rating form) were used in the analysis to represent client and therapist perceptions of the success of therapy.

#### Procedure

Subjects were tested before therapy and after therapy, or after four months, whichever came first. They completed pretest forms sometime between their intake appointment and their first therapy session. At pretest they came into the counseling center and completed the ACL, BSI, Pretest Rating Form, and a demographic form. Subjects were then assigned to therapists according to the normal counseling center procedure, which was that each case was discussed in staff meeting and assigned according to therapist expertise and availability. Some of the subjects were on a waiting list for variable amounts of time when therapists' case loads were full.

The treatment consisted of therapy as it normally occurred at the counseling center during the time of the study. Nine therapists provided therapy from a variety of theoretical orientations and with varying amounts of experience. Three therapists were full time staff psychologists with doctorate degrees and between 9 and 29 years experience. The other six therapists were part-time, students in the

Professional-Scientific Psychology doctoral program at the university and were supervised by the full time staff. These part-time therapists had between 1.5 and 5 years of therapy experience.

Theoretical orientations of the therapists included: Psychoanalytic, Ego Psychology, Rogerian, Cognitive Behavioral, Transactional Analysis, and Existential. The therapists were asked if they used TA to conceptualize their work with clients. Three therapists said yes, five said occasionally or rarely, and one said no. They were also asked if they ever talked to their clients about TA concepts. Four said yes, four said occasionally or rarely, and one said no.

During the time of the study, the counseling center therapists usually worked within a 10-session limit framework. This meant that problem identification and resolution were attempted within the 10-session limit but therapy was extended beyond ten sessions if determined to be necessary to accomplish the therapy goals. The average number of sessions for the subjects of this study was 8.01 with a standard deviation of 6.26 and a range of 1 to 36.

When the subjects finished therapy or after four months, whichever came first, they were posttested. The ACL, BSI and the Client Posttest Rating Form were mailed to the subjects with an addressed, stamped, return envelope. If the forms were not returned within 2-3 weeks, the subjects were phoned to encourage them to complete the forms. Also at posttest, the therapist was asked to complete a Therapist Rating Form.

## CHAPTER IV

## RESULTS

The data were analyzed to answer the four research questions. Changes in scores for Critical Parent, Nurturing Parent, Adult, Free Child and Adapted Child were tested with correlated  $t$ -tests of the difference in means from pretest to posttest. The relationships between the ego state scores and symptom severity were determined by computing Pearson's  $r$  zero-order correlation coefficients between each ego state score at posttest and the BSI Global Severity Index at posttest. The relationships between the change in ego state scores and the client and therapist perceptions of success of therapy were assessed by five multiple-regression equations. The relationships between the change in ego state scores and client pretherapy symptomatology, number of sessions, and therapist experience were also assessed using five multiple regression equations. A probability level of .05 was used to determine statistical significance for all analyses in this study.

Ego State Score Changes

TA theory predicts that Adult, Nurturing Parent, and Free Child ego state functioning should go up and that Critical Parent and Adapted Child ego state functioning should go down as a result of client improvement occurring in psychotherapy. The difference between pretest and posttest means for each of the ACL ego state scores were compared using a correlated  $t$  statistic. The results of this analysis are displayed in Table 2. Since the direction of score changes had been predicted by the theory, one-tail tests of statistical significance were used.

Table 2

Changes in ACL Ego State Scores Pretest to Posttest

Ego State	Pretest		Posttest		<u>t</u>	<u>p</u>
	<u>M</u>	<u>SD</u>	<u>M</u>	<u>SD</u>		
CP	50.61	10.59	48.77	11.64	-1.74	.044
NP	44.84	10.78	48.21	9.58	3.17	.001
A	44.36	9.84	47.95	8.81	3.49	.000
FC	46.25	9.91	47.07	10.06	0.79	.217
AC	56.39	10.55	52.20	9.97	-3.76	.000

Note. n = 56.

There were statistically significant changes in the predicted directions for Critical Parent, Nurturing Parent, Adult, and Adapted Child scores. The change in Free Child scores was not statistically significant, but was in the predicted direction.

Ego State Scores and Collateral Measures of Client Change

To further assess whether the changes in ego state scores related to an underlying mechanism of client change in psychotherapy, the scores were related to three other collateral sources of information: client report of symptom severity (BSI Global Severity Index), client rating of the success of therapy, and therapist rating of the success of therapy.

Relationship between ego state scores and BSI global severity index. Ego state scores and the BSI Global Severity Index were compared at posttest to determine whether there was a relationship between these



two measures of client change. Before comparing these scores, the BSI scores were examined for change from pretest to posttest since it was assumed that the BSI would also be measuring client change only from a different theoretical framework. Means, standard deviations, and correlated  $t$  statistics for the BSI subscales (somatization, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, psychoticism), the Global Severity Index, and the Positive Symptom Total are presented in Table 3. The BSI

Table 3

Changes in BSI Scores Pretest to Posttest

BSI scales <sup>a</sup>	Pretest		Posttest		$t$	$p$
	<u>M</u>	<u>SD</u>	<u>M</u>	<u>SD</u>		
Som	48.88	7.45	43.68	6.87	-5.10	.000
Ob-Com	49.91	6.95	44.36	6.95	-5.87	.000
Int Sen	50.29	9.98	44.34	7.79	-5.52	.000
Dep	48.07	7.65	41.93	6.62	-6.25	.000
Anx	47.86	8.18	41.34	7.22	-6.90	.000
Hos	48.04	8.57	43.70	8.05	-4.37	.000
Phob An	48.02	6.30	44.68	5.15	-3.88	.000
Par Id	51.07	7.76	46.55	8.14	-4.84	.000
Psy	50.66	9.09	44.20	7.65	-6.02	.000
GSI	48.13	8.57	40.57	7.77	-7.92	.000
PS <sup>b</sup>	31.93	9.41	23.55	9.94	-8.04	.000

Note.  $n = 56$ .

<sup>a</sup>Abbreviations correspond with subscale names listed on page 43.

<sup>b</sup>Positive Symptom is a raw score representing the total number of symptoms endorsed. All other scores are standard scores.



scores did change in the predicted direction (lower scores indicate less symptomatology) and these changes were statistically significant. The number of symptoms endorsed went down almost one standard deviation, a raw change from 32 to 24, and the Global Severity Index, which measures magnitude of distress related to each symptom as well as number of symptoms, also went down almost one standard deviation. Next, the relationships between the Global Severity Index and the ego state scores were computed using Pearson  $r$  correlation coefficients. Even though ego state scores and symptom scores were collected at pretest and posttest, only the posttest scores were used in this analysis. Mintz, Luborsky, and Christoph (1979) suggest that posttest scores are more reliable than simple change scores. Since the question is whether ego state scores correlate with another measure of client functioning, posttest scores alone were considered adequate.

According to theory, Critical Parent and Adapted Child functioning should be related to more symptomatology and Adult, Nurturing Parent and Free Child functioning should be related to less symptomatology. The results of this analysis are presented in Table 4. The directions of the correlations were as expected. Critical Parent and Adapted Child scores were positively correlated with symptomatology and Nurturing Parent, Adult, and Free Child were negatively correlated with symptomatology. All correlations except Critical Parent reached statistical significance.

Changes in ego state scores and client and therapist ratings of therapy success. Five multiple regression analyses were used to examine the relationships between the change in ego state scores and the client and therapist ratings of success of therapy. In each equation posttest

Table 4

Zero-order Correlation Coefficients for Ego State  
Scores and the BSI Global Severity Index at Posttest

Ego State	<u>r</u>	<u>p</u>
Critical Parent	.23	.082
Nurturing Parent	-.42	.001
Adult	-.33	.013
Free Child	-.47	.000
Adapted Child	.52	.000

Note. n = 56.

scores for one ego state were entered as the dependent variable and the pretest scores for the same ego state were entered as an independent variable. In this way the variability associated with pretest differences amongst subjects was partialled out leaving the pretest-posttest change variability to be correlated with the remaining independent variables. The client and therapist ratings of success were entered in the equation as independent variables. The results of these analyses are presented in Table 5.

Neither the client nor the therapist ratings of success appear to be related to the changes in ego state scores, with one exception. The client rating of success was correlated to the change in Nurturing Parent at a statistically significant level. The client rating of

Table 5

Summary Statistics for Multiple-Regression Predicting  
Changes in Ego State Scores from Client and Therapist  
Ratings of Success

Source	<u>b</u>	<u>SEb</u>	<u>t</u>	<u>p</u>
CRITICAL PARENT				
Client	-0.73	0.56	-1.29	.204
Therapist	0.38	0.49	0.78	.437
NURTURING PARENT				
Client	1.05	0.46	2.27	.028
Therapist	-0.69	0.40	-1.73	.090
ADULT				
Client	0.46	0.52	0.88	.384
Therapist	-0.28	0.45	-0.63	.535
FREE CHILD				
Client	0.21	0.53	0.41	.686
Therapist	0.86	0.45	1.90	.064
ADAPTED CHILD				
Client	-0.42	0.54	-0.78	.440
Therapist	-0.02	0.46	-0.06	.956

Note. n = 48.

success was not correlated with any of the remaining ego state scores. The therapist rating of success was not related at a statistically significant level to any of the changes in ego state scores.

### Ego State Score Changes and Variables Predictive of Therapy Outcome

The relationships between ego state score changes and three variables that possibly predict outcome (client pretherapy symptomatology measured by BSI Global Severity Index, number of sessions, therapist experience) were assessed using five multiple regression equations. Again each equation had posttest scores for one ego state as the dependent variable and the pretest scores were entered as an independent variable to partial out pretest differences amongst subjects. The three other variables, BSI Global Severity Index at pretest, the number of sessions, and the therapist level of experience, were entered as independent variables. The multiple regression statistics for these analyses are listed in Table 6.

None of the variables related at a statistically significant level to the changes in ego state functioning scores. Subject pretest symptomatology, as measured by the BSI Global Severity Index, was not related to any of the ego state score changes. The Global Severity Index at pretest had a mean standard score of 48.13 and a standard deviation of 8.57. The number of sessions appeared to have little relationship to the changes in ego state functioning also. The number of sessions ranged from 1 to 19, with a mean of 7.48 and a standard deviation of 4.94. (One out-lier, 36, was removed for this analysis.) The level of therapist experience did not contribute to the change in ego state scores either. Thirty-five of the subjects saw a staff psychologist and 21 subjects saw a psychology graduate student.

Table 6

Summary Statistics for Multiple-Regression Predicting  
Changes in Ego State Scores from Pretest GSI, Number of  
Sessions, and Therapist Experience

Predictor	<u>b</u>	<u>SEb</u>	<u>t</u>	<u>p</u>
CRITICAL PARENT				
GSI	-0.09	0.14	-0.68	.497
Sessions	0.11	0.24	0.45	.655
Ther Exp	1.24	2.39	0.52	.607
NURTURING PARENT				
GSI	0.05	0.14	0.37	.710
Sessions	0.25	0.22	1.16	.251
Ther Exp	-2.06	2.08	-0.99	.327
ADULT				
GSI	-0.01	0.12	-0.05	.958
Sessions	0.17	0.20	0.82	.415
Ther Exp	-1.54	1.99	-0.78	.441
FREE CHILD				
GSI	-0.10	0.12	-0.81	.422
Sessions	0.13	0.22	0.60	.552
Ther Exp	-1.04	2.14	-0.49	.628
ADAPTED CHILD				
GSI	0.08	0.14	0.59	.555
Sessions	-0.45	0.23	-1.96	.055
Ther Exp	0.09	2.20	0.04	.969

Note. n = 52.

### Summary

Four out of five ego state scores changed in the predicted direction and were statistically significant. The ego state score that did not change was Free Child.

The relationships between ego state scores and BSI scores at posttest were all in the predicted direction and all except Critical Parent were statistically significant. Neither client nor therapist ratings of success contributed to the change in ego state scores at a statistically significant level. None of the three variables, client pretherapy symptomatology, number of sessions, or therapist experience, contributed to the change in ego state scores at a statistically significant level.

## CHAPTER V

### DISCUSSION

The purpose of this study as stated in chapter 1 was to determine whether the TA theory of ego state change is a viable way of measuring client improvement in psychotherapy, regardless of therapist theoretical orientation. Critical Parent, Nurturing Parent, Adult, Free Child and Adapted Child ego state functioning were measured before and after therapy. Ego state scores were then related to other measures of client change and variables that might be predictive of therapy outcome.

#### Ego State Score Changes

Four out of the five ego state functioning scores changed in the directions predicted by TA theory. All four of these changes were statistically significant. Nurturing Parent and Adult scores went up, and Critical Parent and Adapted Child scores went down. There was not a statistically significant change in Free Child scores.

Critical Parent and Nurturing Parent scores changed in directions that indicate more positive, permissive, and endorsing attitudes toward self and others. It could be said that subjects at posttest were giving themselves more positive strokes and less negative strokes. These changes may have been brought about by the client taking in positive attitudes modeled by the therapist, as well as confronting and rejecting old prohibitive messages, as Berne (1961) suggested.

According to TA theory, an increase in Adult ego state functioning indicates an increase in rational thinking, information-processing, and problem-solving abilities. While these changes appear to have occurred for the subjects of this study, they may or may not be associated with

participation in psychotherapy, since there was no control group for comparison. The subjects were college students and Adult ego state functioning may have increased as a result of participating in college course work. It is most likely, however, that the increase resulted from a combined effect of college course participation and psychotherapy, since both can explain the change.

TA theory also predicted that Free Child ego state functioning would increase and Adapted Child ego state functioning would decrease. A decrease in Adapted Child functioning means that less behavior is dictated by the demands of the Critical Parent. An increase in Free Child would have meant an increase in spontaneous, expressive, and autonomous behavior which emerges as the influence of Critical Parent decreases. Since Critical Parent did go down and Adapted Child also went down, then why didn't Free Child go up?

This question may be understood by thinking of ego state functioning as hierarchically organized. The Child is under the supervision of the Adult and Parent ego states. For example, Berne (1961) described what happens to the personality under the influence of alcohol.

Under the influence of alcohol, for example, the Parent is first anesthetized, so that the child, if depressed or inhibited, can express itself in a more buoyant or freer way, which may lead socially to either increased pleasantness or increased unpleasantness. Next goes the Adult, so that social techniques and objective judgments of physical reality begin to fade. It is only with the strongest doses that the untrammelled Child, confused by its own freedom, begins to pass out as unconsciousness supervenes. The saying that people reveal their true selves when they are drinking means that the Adapted Child who listens to the dictates of the Parent and Adult, gives way to the natural Child as the upper levels of functioning fade away. (pp. 47-48)



Thus, increases in Free Child behavior will depend on the degree of permission allowed in Adult and Parent ego state systems. It is possible that amount of change occurring in subjects was not sufficient to allow a change in Free Child even though Adapted Child did decrease. There may a threshold that change in Adult and Parent functioning has to reach before Free Child functioning increases. Alternately, there may have to be specific qualitative changes in Adult and Parent rather than quantitative changes to produce an increase in Free Child.

It may also be that changes in ego state functioning proceeds in stages. Berne (1961) said that the first task in psychotherapy is to decontaminate the Adult thus increasing reality testing. (By this he meant clarifying boundaries between Adult information and either Child or Parent information.) This is followed by confrontation of the prohibitions of the Critical Parent. Thus increasing Free Child functioning may be the last phase of psychotherapy. This sequence suggests that perhaps the therapy in this study was not long enough to reach the stage where Free Child functioning increases.

Another hypothesis is that the lack of change in Free Child ego state functioning was due to the fact that the subjects were students. The student role requires discipline and adherence to external structure which could be inhibitive of Free Child ego state functioning. The student role may have caused the Free Child functioning to remain constant while the psychotherapy experience was bringing about changes in the other ego states.

### Limitations

There are two points to keep in mind when thinking about the practical significance of the data. First, statistical significance has

limited meaning in this study because the sample was not randomly selected and inference to the general population of psychotherapy clients cannot be made. Second, these changes are based on the subject reporting a few more or less of certain self-descriptive adjectives at posttest. Whether the ego state score changes are related to meaningful shifts in client functioning will be addressed in the discussion of the relationships with the collateral measures of client change.

The sample used was university counseling center clients, which is a unique population and cannot be said to represent psychotherapy clients in general. The subjects were college students, who generally had developmental issues, situational problems, or adjustment reactions rather than more severe pathology. It may be that this population can more easily make changes in ego state functioning due to their higher level of functioning in general.

There was no control group and, therefore, ego state functioning changes cannot be automatically attributed to psychotherapy. The changes may have been due to school enrollment, spontaneous personal development, involvement in other change enhancing activities, or simply the passage of time.

There was also no long-term follow-up of client changes. The posttest was taken at the termination of therapy or after four months whichever came first so there is no way of knowing if the changes were permanent. This may be a moot point, however. In a meta-analysis of 67 studies of psychotherapy outcome, which reported both posttherapy and follow-up data, Nicholson and Berman (1983) found that follow-up data added little to the results. When biasing factors (such as high drop-

out rate and intervening treatment) were accounted for, gains measured at posttest appeared to be durable.

Demand characteristics of this study were considered to be minimal. The therapists did not systematically use TA theory in their therapy, they did not know which of their clients were in the study until posttest, and the clients were blind to the research question (they did not know TA theory was being tested). Since the therapists did not know which clients were subjects, it was assumed that the therapists conducted therapy as they normally would and did not betray the nature of the study to the clients. The therapists' use of TA concepts in therapy varied. Therefore, the treatment variable could have been confounded by an uneven teaching effect, where some of the subjects learned TA concepts from their therapist and other's didn't. However, since the measures used did not refer to the TA concepts and the subjects did not know the research questions, the teaching effect was probably minimal.

### Implications

While acknowledging the limitations of the study, the results suggest that TA theory may well be a viable way of conceptualizing client functioning and change in psychotherapy. This gives some support to therapists who use TA to conceptualize client functioning and to guide their therapy practice. The fact that the changes occurred without a systematic application of TA oriented therapy and in some therapy with no TA influence at all, suggests that therapists practicing TA need not be concerned that the client understand the TA concepts to achieve ego state functioning changes. Also that they do not need to

use only TA language in communication with clients. This ought to give TA therapists more latitude in their practice of therapy.

Future research could explore how these ego state functioning changes occur. Factors related to change may be found in the client-therapist relationship and more specifically the client and therapist behavior in the sessions. Exploring how ego state functioning can change when no TA concepts are used may lead to better understanding of common factors between TA and other theoretical approaches. It might also be interesting to investigate whether the use of TA concepts in therapy increases the degree of change in ego state functioning. Therapy using systematically applied TA concepts could be compared with therapy using no TA concepts to determine whether the former actually increases ego state functioning changes or not.

To make sure ego state functioning changes are actually due to the intervention of psychotherapy, this study should be replicated with a control group, with random assignment if possible. This type of design is difficult to accomplish with therapy clients due to the ethical obligation not to unnecessarily deny services to eligible clients. If such a design could be achieved, perhaps by use of a waiting list group for the control, the changes could more certainly be attributed to the therapy.

### Relationships with Collateral Measures

Given that the ego state functioning scores changed as predicted, were these changes meaningful? Can they be said to represent some underlying process of client change that occurs in psychotherapy? Since an underlying process of client change is a theoretical construct, it cannot be measured directly. To approximate it three other measures

of client change beyond the ego state functioning scores were used. These other measures were then related to the ego state scores to see if the scores converged.

Relationship with BSI. The BSI scores changed just as the ego state scores changed between pretest and posttest. This data suggests that there was a change in the client's subjective experience of distress between pretest and posttest. The amount of change in the Positive Symptom Score and the Global Severity Index was a little more than the overall effect size (.85) found by Smith et al. (1980). They concluded that the .85 effect size represented a positive client change due to psychotherapy. Likewise, the changes in the BSI scores suggest the subjects experienced a positive change during the time they received psychotherapy. Therefore, the ego state score changes may also represent this positive client change. This idea that the two instruments are measuring an underlying process of client change is strengthened by the fact that the two measures correlated in predicted directions with each other. As the symptoms went down, the Adult, Nurturing Parent and Free Child scores went up and the Critical Parent and Adapted Child scores went down.

The correlation between the BSI Global Severity Index and the Critical Parent ego state scores was not statistically significant. This may mean that Critical Parent behaviors are less similar to the BSI symptoms than the other ego state behaviors. For example, while prohibitive and controlling self statements have an effect on the personality, they may not be as closely related to symptoms as the adaptive behaviors that make up Adapted Child functioning.

The BSI and the ego state scores are both measuring client functioning, and the relationships between them are meaningful. Both measures changed as expected during psychotherapy and the BSI scores generally converged with the ego state scores. This suggests that the ego state scores may have in fact measured an underlying mechanism of change and that the change that occurred was meaningful to the clients.

Relationship with client and therapist ratings. Client and therapist global ratings of the success of therapy did not relate to the change in ego state functioning scores, with one exception. The client ratings of success did relate to the change in Nurturing Parent ego state scores.

Because these two measures did not relate consistently with the changes in ego state scores, they may be measuring a different construct. Mintz, Luborsky, and Cristoph (1979) suggested there may be two factors measured in therapy outcome studies, one being the actual change in client adjustment and the other being perceived benefits of therapy. While these two factors overlap somewhat, they are conceptually different. The first is how the client actually changes: what is different in his/her thinking, feeling, and behavior. The second has to do with a perception of change measured against some criteria. It includes the notion of cost/benefit (e.g., Is what I got from therapy worth the effort I put out?). It may be that the ego state scores and the BSI are measuring the first factor, change in adjustment, and the client and therapist ratings of success are measuring the second factor, benefits.

Thus the client rating of success may be measuring how satisfied the client is relative to what he/she expected. Clients come into

therapy with various expectations. These do not always include the expectation that they will change. Some clients come for relief from painful feelings; others come for someone to talk to. How the client judges the success of therapy may not be based on actual changes but on how well their expectations were met.

Another explanation may be that the clients did not perceive the changes in ego state functioning. As individuals change, they may forget somewhat how they thought, felt or behaved initially. They may know that problems they had before are gone or lessened but not attribute that to their own changes. Alternately, they may notice the changes but not attribute them to the therapy experience.

The change in Nurturing Parent was related to client perception of change, however. There could be several explanations why Nurturing Parent, and not other ego state functioning changes, were related to client rating of success. First, it may be that the change in this ego state functioning was more in line with the client expectations and was, therefore, seen as a benefit from therapy. Second, changes in Nurturing Parent thoughts, feelings, and behaviors may be more prominent and noticeable to the client than aspects of the other three ego states that changed (Adult, Critical Parent, Adapted Child). Third, an increase in Nurturing Parent may have been attributed to therapy because the behaviors were modeled by the therapist and the connection was clear. The other changes may have been less clearly associated with therapy.

The therapists' ratings of success were not related to any of the ego state score changes. Again, it may be that the therapists' rating of success is conceptually different from perceived change in client functioning. The therapist also has expectations from therapy and the



rating of success may have been a measure of cost/benefit for the therapist as well. The therapists could have been assessing whether the change in the client was adequate given the effort they both put forth and whether the treatment goals were met or not, rather than simply reporting client change.

If the client and therapist ratings of success were really measuring satisfaction rather than actual change in functioning, then could different instruments measure perception of change? If so, then the relationships between ego state functioning changes and client and therapist perceptions of change, rather than satisfaction, could be explored.

Another explanation for the lack of relationship between ratings of success and ego state score changes may be the statistics used. The studies cited in the review of literature (Green et al., 1975; Mintz et al., 1979) indicated relationships between client and therapist global ratings of benefits and pretest/posttest changes in clients. These two studies used correlations between residual gain scores and global ratings rather than multiple regression equations, which were used in this study. Residual gain scores take into account one factor that multiple regression does not and that is the correlation between pretest scores and amount of gain. Mintz et al. (1979) states:

Not only does the residual gain score appear to represent that component of change which is not confounded with or affected by initial adjustment level but it also appears to represent an important component of overall perception of benefits from treatment. (p. 329)

Thus, multiple regression analysis appears to yield a slightly different score than residual gain scores and that difference may account for a



lack of relationship between client and therapist ratings of success and ego state scores changes in this study.

Thus, there are two possible explanations for the lack of relationship between ratings of success and ego state change scores. The global ratings of success may be measuring cost/benefit which is conceptually different from a change in functioning. Therefore, the measures would not necessarily relate. Alternately, the statistical procedure used in this study yielded a slightly different score than those used in the literature validating the use of global ratings. Thus, the lack of relationship could have been due to use of a less sensitive score. While the client and therapist ratings of success did not converge with ego state score changes, this fact does not contradict the idea that ego state scores are measuring some underlying process of client change.

#### Relationships with Other Variables

None of the variables hypothesized to predict psychotherapy outcome had statistically significant relationships with the changes in ego state functioning scores. The clients' pretherapy distress, measured by the pretest BSI Global Severity Index, did not predict changes in ego state functioning. Number of sessions and therapist level of experience did not predict ego state functioning changes either.

Client pretest symptomatology. The lack of relationship may be due to the fact that the subject sample was relatively homogeneous in regard to diagnosis. Studies which have shown a difference in outcome based on initial client distress may have sampled from a larger variety of diagnoses. The subjects in this study presented with developmental issues, adjustment problems, relationship difficulties, academic

troubles and mood disturbance rather than major psychotic disorders. Thus for clients with less severe diagnoses, changes in ego state functioning appear not to be related to the clients' initial symptomatology.

Number of sessions. Number of sessions did not relate to the changes in ego state scores. This may mean that change in ego state functioning is not linear over time. Change may occur in bursts, or may be curvilinear over time similar to a learning curve with more change initially and less in later sessions. Another explanation may be that not all clients change at the same rate. Some may change very quickly in a couple of sessions and others may take longer. There may also be a different amount of change possible for different individuals. Some may be able to make large changes and others smaller.

The therapy provided was short-term and it may be that replication of this study with longer term therapy may demonstrate an effect for number of sessions. It may also be true that the relationship between number of sessions and ego state change is not a simple one and actually includes other intervening variables. It does appear, however, that within the short term format, ego state changes can occur just as well in fewer sessions as it can in more sessions. Further examination of the relationships between number of sessions, time, individual differences and ego state changes may reveal how those changes unfold.

The lack of relationship between number of sessions and ego state changes coincides with the findings of Smith et al. (1980), who found in their meta-analysis that length of therapy did not seem to contribute consistently to its effectiveness. They said:

The effect of therapy bore no simple or consistent relationship to its duration. The curve that relates average effect size to number of hours of therapy twists and dips

erratically. It seems to result more from what kinds of clients and problems are treated in therapies of different lengths than from some intrinsic relationship between the length of therapy and its benefits. (p. 115)

Therapist experience. Client changes occurred regardless of the amount of experience of the therapist. Therapist experience was defined as professional staff or student therapist. The study did not assess the effect of therapist experience with and use of TA principles in therapy. This study addressed whether more or less experience had an effect. Replication of the study, with controlled application of TA/non-TA treatments, could include a variable for amount of experience the therapist had with TA, in the TA treatment group. This would assess the effect of therapist experience with TA on ego state functioning changes.

This finding, that therapist experience does not relate to ego state changes, also coincides with the Smith et al. (1980) results. They found no significant relationship between therapist experience and therapy outcome. About therapist experience they said:

For the body of research, however, there was no relationship between the years of experience of the therapists in a study and the magnitude of therapeutic effect produced in that study. (p. 117)

None of the factors thought to possibly predict therapy outcome had an effect on ego state changes. Understanding what client, therapist, and therapy variables contribute to the changes in ego state functioning would be helpful in understanding how the changes take place. Further research is needed to explore the effects of variables or effects of interactions of variables that may predict changes in ego state functioning.

### Conclusions

The findings can be summarized as follows:

1. Ego state functioning changed as predicted by TA theory with one exception. There was no change in Free Child. This suggests that the TA ego state concepts may well be a viable method of measuring client change in therapy.
2. Ego state scores converged with BSI scores. Both changed as predicted and correlated with each other as predicted with one exception. Critical Parent was not related with the BSI at a statistically significant level. The ego state scores and BSI General Severity Index generally converged suggesting they might both be measuring some underlying process of client change.
3. Client and therapist ratings of the success of therapy were not related to changes in ego state functioning, with one exception. Nurturing Parent changes were related to client rating of success. The lack of relationships may have been due to the fact that ratings of success may be measuring benefit rather than actual client change. The lack of convergence between ego state score changes and client and therapist global ratings of success does not necessarily contradict the idea that ego state scores can be used to measure client change.
4. There were no relationships between client pretherapy symptomatology, number of sessions, and therapist experience and the changes in ego state functioning. Client, therapist, or therapy variables that can predict changes in ego state functioning are yet unknown and additional research is needed to understand how change in ego state functioning occurs.

#### Recommendations for Further Study

Further research could investigate several issues. Replication of this study with a control group would determine whether ego state functioning changes are actually due to psychotherapy or not. While it is unethical to deny services to eligible clients, perhaps a waiting list could serve as a control group. Ideally, the subjects would be randomly assigned to treatment/no-treatment conditions. Replication of this study might also include other client populations and other therapy settings.

Exploration of how the changes in ego state functioning occur and what variables, or interaction of variables, contribute to the change might yield valuable information that could be directly applied in

therapy. Teaching TA concepts to clients and other overt applications of TA theory in therapy sessions could be compared with therapy totally free of TA theory to see if the former results in greater change in ego state functioning. Also, more complex variables (such as the interaction between client symptomatology and client-therapist relationship) could be explored as possible predictors of ego state change.

do changes in ego state functioning correlate with changes measured from other theoretical orientations? If the changes found in this study do represent some part of an underlying mechanism of change, then the TA theory of change may overlap with other theories of change. For example, adult ego state functioning may correlate with a change in rational thinking as defined by Ellis or Adapted Child ego state functioning may correlate with phobias, etc. This could be easily studied by administering a battery of measures, representing different theoretical orientations and including the ACL, before and after therapy.

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## APPENDICES

Appendix A  
Informed Consent

THERAPY OUTCOME STUDY  
INFORMED CONSENT

The U.S.U. Counseling Center is participating in a research study examining the effects of therapy. The study will test the validity of one theory of how people change. We are asking if you would be willing to participate in this study.

To participate, you will fill out three paper and pencil tests and one demographic form before you start therapy and three paper and pencil tests at the end of therapy or after four months, whichever ever comes first. The researcher would also contact your therapist so he/she can fill out a questionnaire at the end of therapy.

The total time you will be spending will be approximately 1/2 hour to complete the forms before you begin therapy and approximately 1/2 hour to complete the forms at the end. The total time commitment is approximately 1 hour.

All of the paperwork that you complete will be kept confidential. Your information will be identified with an ID number only and all of the forms you fill out for the study will be kept in a locked file cabinet accessible only to the primary researcher.

The results of this study will be reported as group data only.

The only cost to you for participating will be a small amount of your time. The benefit to you for participating will be access to your individual test results if you choose and access to the final report.

Your services at the U.S.U. Counseling Center will not be affected in any way by whether you participate in this study or not. If you do agree to participate, you have the right to withdraw from the study at any time.

If you would like more information about the study, please ask to speak to Judith Emerson, M.S.

CONSENT TO PARTICIPATE  
IN COUNSELING CENTER RESEARCH STUDY

I have read the Informed Consent and I consent to participate in this study on the effects of therapy. I agree to complete one demographic form and three paper-and-pencil tests before I begin therapy and three paper-and-pencil tests after I have completed therapy or at the end of four months, which ever occurs first.

I agree to being contacted by the researcher at the end of therapy or at the end of four months to set up a time to complete the post test.

I agree to the researcher contacting my therapist at the end of therapy so the therapist can fill out a questionnaire.

\_\_\_\_\_  
signature

\_\_\_\_\_  
date

\_\_\_\_\_  
witness

Appendix B  
Client Rating Form - Pretest and Posttest

ID# \_\_\_\_\_

Date: \_\_\_\_\_

## PRETEST RATING FORM

Please respond to each statement as it applies to how you are now.

Circle your answers using the following code:

- 1 = strongly agree
- 2 = agree
- 3 = undecided
- 4 = disagree
- 5 = strongly disagree

- |  |   |   |   |   |   |
|--|---|---|---|---|---|
| 1. I usually know what other people expect of me in social situations. | 1 | 2 | 3 | 4 | 5 |
| 2. I experience a variety of feelings.                                 | 1 | 2 | 3 | 4 | 5 |
| 3. I get along fairly well with other people.                          | 1 | 2 | 3 | 4 | 5 |
| 4. I can usually get things done when I decide I want to.              | 1 | 2 | 3 | 4 | 5 |
| 5. I am effective enough at work or school.                            | 1 | 2 | 3 | 4 | 5 |
| 6. I am comfortable with the way I act most of the time.               | 1 | 2 | 3 | 4 | 5 |
| 7. I have at least one close friend.                                   | 1 | 2 | 3 | 4 | 5 |
| 8. I usually have realistic expectations of myself and others.         | 1 | 2 | 3 | 4 | 5 |
| 9. I can express my feelings when I want to.                           | 1 | 2 | 3 | 4 | 5 |
| 10. I do <u>not</u> worry very much.                                   | 1 | 2 | 3 | 4 | 5 |

ID# \_\_\_\_\_

Date: \_\_\_\_\_

## POSTTEST RATING FORM

Please respond to each statement as it applies to how you are now.

Circle your answers using the following code:

- 1 = strongly agree
- 2 = agree
- 3 = undecided
- 4 = disagree
- 5 = strongly disagree

1. I usually know what other people expect of me in social situations. 1 2 3 4 5
2. I experience a variety of feelings. 1 2 3 4 5
3. I get along fairly well with other people. 1 2 3 4 5
4. I can usually get things done when I decide I want to. 1 2 3 4 5
5. I am effective enough at work or school. 1 2 3 4 5
6. I am comfortable with the way I act most of the time. 1 2 3 4 5
7. I have at least one close friend. 1 2 3 4 5
8. I usually have realistic expectations of myself and others. 1 2 3 4 5
9. I can express my feelings when I want to. 1 2 3 4 5
10. I do not worry very much. 1 2 3 4 5
11. Please rate the success of your therapy by circling one number:

No success

Very successful

1 2 3 4 5 6 7 8 9 10



Appendix C  
Therapist Rating Form

ID# \_\_\_\_\_

Date: \_\_\_\_\_

## THERAPIST POSTTHERAPY RATING

Please answer the following questions for your client,  
\_\_\_\_\_.

Circle your answer using the following code:

- 1 = strongly agree
- 2 = agree
- 3 = undecided or no knowledge
- 4 = disagree
- 5 = strongly disagree

- |  |   |   |   |   |   |
|--|---|---|---|---|---|
| 1. Client understands social role expectations.  | 1 | 2 | 3 | 4 | 5 |
| 2. Client is aware of a variety of emotions.   | 1 | 2 | 3 | 4 | 5 |
| 3. Client reports getting along fairly well with other people.                           | 1 | 2 | 3 | 4 | 5 |
| 4. Client reports being able to get things done when he/she wants to.                    | 1 | 2 | 3 | 4 | 5 |
| 5. Client reports being fairly effective at work or school.                              | 1 | 2 | 3 | 4 | 5 |
| 6. Client reports feeling comfortable with the way he/she acts most of the time.         | 1 | 2 | 3 | 4 | 5 |
| 7. Client reports having at least one close friend.                                      | 1 | 2 | 3 | 4 | 5 |
| 8. Client has realistic expectations of self and others.                                 | 1 | 2 | 3 | 4 | 5 |
| 9. Client can express feelings.  | 1 | 2 | 3 | 4 | 5 |
| 10. Client reports no excessive worry.   | 1 | 2 | 3 | 4 | 5 |
| 11. Client has met goals of therapy and termination is appropriate.                      | 1 | 2 | 3 | 4 | 5 |
| 12. Rate the overall success of therapy with this client to date by circling one number: |   |   |   |   |   |

No success

Very successful

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

Number of sessions with client: \_\_\_\_\_

Therapy terminated? \_\_\_\_ yes \_\_\_\_ no

Diagnosis: Axis I \_\_\_\_\_

Axis II \_\_\_\_\_

## Vita

JUDITH EMERSON

## Work:

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## EDUCATION:

Doctoral candidate in Professional-Scientific Psychology  
Utah State University  
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M.S. Therapeutic Recreation  
San Jose State University  
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B.S. Psychology  
Portland State University  
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## WORK EXPERIENCE:

Psychology Intern

Delaunay Mental Health Center  
Portland, Oregon

Provide individual, group, and family therapy to children, adolescents and adults. Complete psychological assessments of children, adolescents and adults including use of objective and projective testing.

Graduate Assistant

U.S.U. Counseling Center  
Utah State University

Individual and group therapy for students. Psychological evaluations. Workshops to university groups on topics such as stress management and self-esteem enhancement.

Research Assistant

Early Intervention Research Institute  
Developmental Center for Handicapped Persons  
Utah State University

Collected, managed and analyzed data for study examining effects of parent involvement in early intervention programming. Conducted literature review. Presented findings at regional conference.

Recreation Therapist

Veteran's Administration Domiciliary  
White City, Oregon

Planned, implemented and evaluated goal-oriented leisure programming for 120-bed inpatient facility. Taught leisure skill building classes and took patients on variety of outings to the community and natural settings.

Protective Services Caseworker

Children's Services Division  
State of Oregon  
Medford, Oregon

Investigated child abuse and neglect cases from the initial report through case disposition. Wrote reports for juvenile court. Specialized in sexual abuse cases and led adolescent survivors' group.

Specialized Recreation Supervisor

Park and Recreation Department  
City of Eugene  
Eugene, Oregon

Supervised staff of recreation therapists who delivered services to special needs populations using a community center classes format.

Exceptional Friendship Program Coordinator

Y.M.C.A.  
University of Oregon  
Eugene, Oregon

Directed program for special needs children modeled after Big-Brother/Big-Sister. Recruited and trained volunteers.

Recreation Supervisor

Easter Seals Society of Marin County  
San Rafael, California

Designed and led recreation programs for children, adolescents and adults with physical and cognitive disabilities and mental disorders.

Play Specialist

Charing Cross Hospital, London, England

Summer intern. Worked with children to reduce trauma of hospitalization through medium of play.

## PROFESSIONAL PRESENTATIONS:

"A systems View of Families of Preschoolers with Down Syndrome"  
Presentation at the Council for Exceptional Children  
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Presentation at the Council for Exceptional Children, Division  
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## PAPERS:

Emerson, J. & Barnett, S. (1988). A Systems View of Families of a Preschooler with Down Syndrome. Unpublished paper, Early Intervention Research Institute, Utah State University.

Emerson, J. & Pezzino, J. (1987). Family Resources and Social Support as Mediators of Perceived Stress in Families with Handicapped Preschool Children. Unpublished paper, Early Intervention Research Institute, Utah State University.

Pezzino, J, Mott, S, & Waidler, J. (1986). Battelle: Concurrent Validity. Unpublished paper, Early Intervention Research Institute, Utah State University.

Emerson, J. (1977) A Follow-up Study of Students Admitted to the Therapeutic Recreation Services Administration Graduate Program, S.J.S.U. 1967-1976. Unpublished Master's degree paper, San Jose State University

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American Psychological Association, Student member since 1985  
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